



H1 Hip Primary

Important:

Please tick relevant boxes. All component stickers should be affixed to the accompanying 'Minimum Dataset Form Component Labels Sheet'. Please ensure that all sheets are stapled together.

All fields are Mandatory unless otherwise indicated

REMEMBER! MAKE A NOTE OF THE SLJR REFERENCE NUMBER WHEN YOU ENTER THIS DATA SLJR REF:

PATIENT IDENTIFIERS

Forename(s)			
Surname			
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Not Specified <input type="checkbox"/>
Date of Birth	Date :	Month :	Year :
Patient Address			
Patient District			
NIC No		BHT No	
Patient Phone Number(s)	Mobile :	Home :	
Patient Body Measurements	Height (In m)		BMI Value
	Weight (In Kg)		
	Not Available <input type="checkbox"/>		
Pre-Op Oxford Hip Score			

OPERATION DETAILS

Hospital			
Operation Date	Date :	Month :	Year :
Anaesthetic Types (select all that apply)	General <input type="checkbox"/>	Regional - Epidural <input type="checkbox"/>	Regional - Spinal (Intrathecal) <input type="checkbox"/>
	Regional - Nerve Block <input type="checkbox"/>		
Patient ASA Grade	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Operation Funding	Government Hospital Implants <input type="checkbox"/>	Done in a Government Hospital with President's Fund <input type="checkbox"/>	Done in a Government Hospital without President's Fund <input type="checkbox"/>
	Done in a Private Hospital <input type="checkbox"/>		

SURGEON DETAILS			
Consultant in Charge			
Operating Surgeon			
Operating Surgeon Grade	Consultant <input type="checkbox"/>	Senior Reg <input type="checkbox"/>	Reg <input type="checkbox"/>
First Assistant Grade	Consultant <input type="checkbox"/>	Other <input type="checkbox"/>	

KNEE PRIMARY PROCEDURE DETAILS		
Side	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Indications for Implantation (Select all that apply)	Osteoarthritis <input type="checkbox"/>	Inflammatory Arthropathy <input type="checkbox"/>
	Congenital Dislocation / Dysplasia of the Hip <input type="checkbox"/>	Avascular Necrosis (AVN) <input type="checkbox"/>
	Trauma - Acute (e.g. Neck of Femur) <input type="checkbox"/>	Failed Hemi-Arthroplasty <input type="checkbox"/>
	Perthes <input type="checkbox"/>	Metastatic Cancer/Malignancy <input type="checkbox"/>
	Trauma – Chronic <input type="checkbox"/>	Previous Hip Surgery - non-Trauma related <input type="checkbox"/>
	Previous Arthrodesis <input type="checkbox"/>	Previous Infection <input type="checkbox"/>
	SUFE <input type="checkbox"/>	Skeletal Dysplasia <input type="checkbox"/>
		Other <input type="checkbox"/>

SURGERY			
Fixation Type	Cemented <input type="checkbox"/>	Uncemented <input type="checkbox"/>	Hybrid <input type="checkbox"/>
	Reverse Hybrid <input type="checkbox"/>	Resurfacing <input type="checkbox"/>	
Bearing Couple	Metal on Poly <input type="checkbox"/>	Ceramic on Poly <input type="checkbox"/>	Ceramic on Ceramic <input type="checkbox"/>
			Other <input type="checkbox"/>
Patient Position	Lateral <input type="checkbox"/>		Supine <input type="checkbox"/>
Approach	Hardinge/Anterolateral <input type="checkbox"/>	Posterior <input type="checkbox"/>	Direct Anterior <input type="checkbox"/>
	Trochanteric Osteotomy <input type="checkbox"/>	Other <input type="checkbox"/>	
Per- Operative Antibiotics	Cefuroxime or Other Cephalosporin <input type="checkbox"/>	Vancomycin <input type="checkbox"/>	Clindamycin <input type="checkbox"/>
	Teicoplanin <input type="checkbox"/>		
Anti-microbial incise drape (e.g. Ioban) used?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
Tranexamic acid given?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
Minimally Invasive Technique Used?	Yes <input type="checkbox"/>		No <input type="checkbox"/>
Computer Guided Surgery Used?	Yes <input type="checkbox"/>		No <input type="checkbox"/>

THROMBOPROPHYLAXIS REGIME (Intention to Treat)				
Chemical (In Hospital)	Aspirin	<input type="checkbox"/>	Direct Thrombin Inhibitor (e.g. Dabigatran)	<input type="checkbox"/>
	LMWH	<input type="checkbox"/>	Factor Xa Inhibitor (e.g. Rivaroxaban/Apixaban)	<input type="checkbox"/>
	Pentasaccharide (e.g. Fondaparinux)	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Warfarin	<input type="checkbox"/>	None	<input type="checkbox"/>
Mechanical	Foot Pump	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Intermittent Calf Compression	<input type="checkbox"/>	None	<input type="checkbox"/>
	TED Stockings	<input type="checkbox"/>		

BONE GRAFT USED		
Was Femoral Bone graft used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was Acetabular Bone graft used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

SURGEON'S NOTES

INTRA-OPERATIVE EVENT			
Untoward Intra-Operative Event?	None <input type="checkbox"/>	Calcar Crack <input type="checkbox"/>	Pelvic Penetration <input type="checkbox"/>
	Shaft Fracture <input type="checkbox"/>	Shaft Penetration <input type="checkbox"/>	Trochanteric Fracture <input type="checkbox"/>
	Other <input type="checkbox"/>		

Implant Stickers			
Components Used?	Zimmer – NexGen <input type="checkbox"/>	Exactech – Optetrak <input type="checkbox"/>	Depuy - Corial and Duraloc <input type="checkbox"/>
Bone Cement?	Palacos R+G <input type="checkbox"/>	Palacos LV+G <input type="checkbox"/>	Copal G+C <input type="checkbox"/>
	Biofix <input type="checkbox"/>	Gentafix 1 <input type="checkbox"/>	